34.0.0 CORRECTIVE ACTION

34.1.0 Overpayments

An "overpayment" occurs when Medicaid (MA) benefits are paid for someone who was not eligible for them, or when MA payments are made in an incorrect amount. The amount of recovery may not exceed the amount of the MA benefits incorrectly provided. Some examples of how overpayments occur are:

- Concealing or not reporting income or assets.
- Failure to report a change in income or assets.
- Providing misinformation, at the time of application, regarding any information that would affect eligibility.

34.1.1 Recoverable Overpayments

Initiate recovery for a MA overpayment if the incorrect payment resulted from one of the following:

1. Client Error

Client error exists when an applicant, recipient, or any other person responsible for giving information on the client's behalf, unintentionally misstates facts, which results in the client receiving a benefit that s/he is not entitled to or more benefits than s/he us entitled to. Client error occurs when there is a:

- Misstatement or omission of facts by a client, or any other person responsible for giving information on the client's behalf, at a MA application or review.

- Failure on the part of the client, or any person responsible for giving information on the client's behalf, to report changes in income or assets.

  A MA client is responsible for notifying his/her Economic Support (ES) worker of changes within 10 days of the occurrence.

An overpayment occurs if the change would have adversely affected eligibility benefits or the post eligibility contribution amount (cost share, patient liability).

2. Fraud

Fraud is also known as Intentional Program Violation (IPV). Fraud occurs when a client intentionally omits or provides erroneous information at the time of

34.1.1 Recoverable Overpayments (cont.)

application or review. If there is a suspicion that fraud has occurred, see 34.4.0 for information about referral to the District Attorney (DA).

3. Client Loss of an Appeal

Benefits a client receives due only to a fair hearing order can be recovered if the client loses the appeal.

A client may choose to continue to receive benefits pending an appeal decision. If the appeal decision is that the client was ineligible, the benefits received while awaiting the decision can be recovered. If an appeal results in an increased patient liability, cost share, or premium, recover the difference between the initial amount and the new amount.

34.1.2 Non-Recoverable Overpayments

Do not initiate recovery for a MA overpayment if it resulted from a non-client error, including the following situations:

- The client reported the change timely, but you could not close the case or reduce the benefit due to the 10-day notice requirement.
- Agency error (keying error, math error, failure to act on a reported change, etc).
- Normal prospective budgeting projections based on best available information.
- A change in the MA category if the benefits in the new category are the same as the original, and the post-eligibility contribution, if any, remains the same.

Example. Mom and child are on AFDC-MA. They concealed income which would have made the mom ineligible. The child would still have been eligible under Healthy Start. Only recover the incorrect payments made for the mom.

34.2.0 Overpayment Calculation

34.2.1 Overpayment Period

If the overpayment is a result of a misstatement or omission of fact during an initial MA application, determine the period for which the benefits were determined incorrectly and determine the appropriate overpayment amount (34.2.2).

34.2.1 Overpayment Period (cont.)

The ineligible period should begin with the application month.

For ineligible cases, if the overpayment is a result of failure to report a change, calculate the date the change should have been reported and which month the case would have closed or been adversely affected if the change had been reported timely.

For ineligible cases, if the overpayment was the result of fraud, determine the date the fraudulent act occurred. The period of ineligibility should begin the date the case would have closed or been adversely affected allowing for proper notice. If an overpayment exists, but the case is still being investigated for fraud, establish the claim so collection can begin promptly. Prosecution should not delay recovery of a claim.

34.2.2 Overpayment Amount

Use the simulation function in CARES to determine a client's eligibility, nursing home liability, premium or cost share (if applicable) based on the corrected information (CARES Guide Chapter VIII, 1.4.1). Use the actual income received by the client in determining if an overpayment has occurred.

To calculate the overpayment amount, use the RC (recipient claims) screen on MMIS. The overpayment amount depends on the MA category and whether the case is fee-for-service or enrolled in a HMO.

If the client would have been ineligible for the time period in question, recover the:

- Amount paid for the medical services provided if the case is fee-for-service.

- Managed care organization's capitation rate, less any contribution made by the client (ex. premium, cost share) if the case members are enrolled in a MA managed care organization. The capitation rate is the monthly amount MA pays to the client's managed care organization.

For the overpayment amounts for institutional (34.2.2.1), waiver (34.2.2.1), BadgerCare (34.2.2.3), Medicaid Purchase Plan (34.2.2.3), deductible (34.2.2.2) and Family Planning Waiver (FPW) 34.2.2.3.1 cases see the appropriate sections.

34.2.2.1 Increased Liability, Cost Share

If a misstatement or omission of fact results in an increased nursing home liability or waivers cost share, the difference between the correct liability/cost share amount and the one the client originally paid is the overpayment amount.

Do not send a 3070 to retroactively increase the patient liability on MMIS.

Family Care
For Family Care (FC) cases in which an omission of fact results in an increased Family Care liability or cost share, complete the following:

1. Recalculate the cost share or FC liability for any months that would have been affected.

2. Calculate the difference between the paid cost share or FC liability amount and the new cost share or FC liability amount.

3. Send the client a notice indicating the correct cost share for the months in question. Indicate on the notice the cost share amount still owed to the Care Management Organization (CMO) for each month in question. Do not attempt to recover the overpayment.

4. Report the new cost share amount to the CMO.

It is the CMO's responsibility to collect the difference between the cost share already paid and the correctly calculated cost share amount. This amount is not an overpayment of MA funds, but is the amount that the client owes the CMO directly.

34.2.2.2 Deductible

If a client error increases the deductible before the deductible is met, there is no overpayment. Recalculate eligibility and notify the client of the new deductible amount.

If the client met the incorrect deductible and MA paid for services after the deductible had been met, there is an overpayment. Recover the difference between the correct deductible amount and the previous deductible amount.

If the client was ineligible for the deductible, determine the overpayment amount. If the client prepaid his/her deductible, deduct any amount s/he paid toward the deductible from the overpayment amount.

34.2.2.3 Premiums

If a BadgerCare (BC) or Medicaid Purchase Plan (MAPP) case was still open for the timeframe in question, but there was an increase in the premium, recover the difference between the premium paid and the amount owed for each month in question. To determine the difference, determine the premium owed and view the premium amount paid on CARES screen AGPT.

BadgerCare
If the case was ineligible for BC, recover the amount of medical claims paid by the state and/or the capitation rate. Deduct any amount paid in premiums (for each month in which an overpayment occurred) from the overpayment amount (34.2.2).

MAPP
If the case was ineligible for MAPP, recover the amount of medical claims paid by the state. Deduct any amount s/he paid in premiums (for each month in which an overpayment occurred) from the overpayment amount.

34.2.2.3.1 Overpayments for Individuals Eligible for FPW benefits

If an individual or case was ineligible for MA or BC but would have been eligible for FPW benefits the calculation of the ultimate Medicaid overpayment amount is as follows:

1. If the incorrect/overpaid Medicaid benefits were “fee for service” medical claims paid by the state, recover the amount of benefits that were actually paid by the state minus any premiums which the client may have paid and the amount of any actual FPW services that were provided.

2. If the incorrect /overpaid Medicaid benefits were paid by an HMO, recover the HMO capitation rate paid by the state minus any premiums which the client may have paid and the “average” (currently $28.60) monthly cost of Medicaid FPW services.

34.2.2.4 Determining Liable Individual

Except for minors**,** collect overpayments from the MA client, even if the client has authorized a representative to complete the application or review for him/her.

Example. Sofie applied for MA in December, and at that time designated her daughter, Lynn, as her authorized representative. Lynn did not report some of her mother's assets when she applied, which would have resulted in Sofie being ineligible for MA. Sofie was determined to be ineligible for MA from December through March. Recover from Sofie for any benefits that were provided to her from December through March.

If a minor received MA in error, make the claim against the minor's parent(s) or legally responsible relative if the parent or legally responsible relative was living with the minor at the time of the overpayment.

34.3.0 Overpayment Process

Follow the instructions in Chapter VIII of the CARES Guide to enter the claim. CARES issues a repayment agreement the first business day of the month following the date the claim was entered. You are responsible to:

- Enter the claim into CARES.
- Send a manual Medicaid Overpayment Notice (HCF 10093) indicating the reason for the overpayment and the period of ineligibility.
- Record the completed and signed repayment agreement on CARES screen BVPA within five days of receipt.
- Record payments on CARES screen BVCP within five days of receipt.

CARES will:

- Track the issuance of notices of non-payment and send automated dunning notices (i.e. past due notices).
- Refer past due claims for further collection action (i.e. tax intercept) to the Central Recoveries Enhanced System (CRES).
- Close the claim when the balance is paid.

34.3.1 Client Notice

Notify the client or the client's representative of the period of ineligibility, the reason for his/her ineligibility, the amounts incorrectly paid, and request arrangement of repayment within a specified period of time.

34.4.0 Refer to District Attorney

See IMM Ch. I, Part E and Ch. II, Part D for referral criteria when fraud is suspected. The agency may refer the case to the state fraud investigation service provider where fraudulent activity by the client is suspected. If the investigation reveals a client may have committed fraud, refer the case to the district attorney or corporation counsel for investigation. The district attorney or corporation counsel may prosecute for fraud under civil liability statutes. The agency may seek recovery through an order for restitution by the court of jurisdiction in which the client or former client is being prosecuted for fraud.

34.5.0 Fair Hearing

The ESA's decision concerning ineligibility and amounts owed may be appealed through a fair hearing. During the appeal process the agency may take no further recovery actions pending a decision.

34.6.0 Agency Retention

The ESA can retain 15% of the payments recovered. See IMM Ch. II, Part A, 3.2.1 and Ch. II, Part D, 9.0.0.

34.7.0 Restoration of Benefits

If it is determined that a client's benefits have been incorrectly denied or terminated, restore his/her MA from the date of the incorrect denial or termination through the time period that s/he would have remained eligible.

If the client was incorrectly denied or terminated for BC or MAPP with a premium obligation. Allow the client to pick which months s/he would like to receive benefits. Collect all premiums owed for all prior months before certifying the client for the months s/he chose.

If a client already paid for a MA covered service, inform the client that s/he will need to contact his/her provider to bill MA

34.7.0 Restoration of Benefits for services provided during that time. A MA provider must refund the amount that MA will reimburse for the service. The provider may choose to refund up to the full amount billed to the client, but that decision is entirely optional.

34.8.0 Incorrect Client Contribution

34.8.1 Premiums

If it is determined that a premium amount was incorrectly calculated for BC or MAPP and would result in a refund for the client, determine the correct premium amount for each month in which it was incorrect.

When reporting the refund to the BadgerCare or MAPP Unit, include the:

- The client's Social Security Number.
- Months for which a refund needs to be issued.
- New premium amount.
- Old premium amount.

Indicate whether there is a hardship situation that requires the refund to be processed more quickly.

34.8.1.1 BadgerCare

If the premium was recalculated and reduced for prior month(s), report the premium refund to the BadgerCare Unit by:

- Telephone: 1 (888) 907-4455
- Fax: (608) 251-1513

When submitting a fax, write "Attn: BC Premium Refunds".

34.8.1.2 Medicaid Purchase Plan (MAPP)

If the premium was recalculated and reduced for prior month(s), report the premium refund to the MAPP Unit by:

- Telephone: 1 (888) 907-4455
- Fax: (608) 251-8185

When submitting a fax, write "Attn: MAPP Premium Refund"